COMPLIANCE PEER REVIEW

HEMAN G. STARK YOUTH CORRECTIONAL FACILITY

Prepared by:

California Department of Corrections and Rehabilitation
Office of Audits and Compliance

Preliminary Report

April 2008

STUDENT ENROLLMENT

Division of Juvenile Justice Education Manual, Sections 4065-4067, and Subsection of the California Education Authority, Section III (b)

Office of Audits and Compliance Staff
George Valencia, Youth Authority Administrator
Havon Mcleod, Assistant Principal

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EXECUTIVE SUMMARY

The Office of Audits and Compliance, Compliance/Peer Review Branch (CPRB) reviewed the Division of Juvenile Justice (DJJ) Education Manual, Sections 4065-4067, and sub-sections of the California Education Authority (CEA), Section III (b), to determine whether Lyle Egan High School (LEHS) at Heman G. Stark Youth Correctional Facility (HGSYCF) was in compliance with the policies stating that students are to be enrolled into an appropriate educational program within four days of arrival to his/her assigned facility.

The review period was August 1, 2007 through January 31, 2008. During this period, it was determined that LEHS had a total of 290 wards that did not have their high school diploma or their General Education Certificate. There were four categories of students; English Learner, Special Education, Special Education/English Learner, and General Education students. The CPRB reviewed 30 student records from the Ward Information Network (WIN), totaling an approximate sample size of 10 percent. From the English Learner category, 10 records were reviewed. In the Special Education category, five records were reviewed. From the General Education category, 10 records were reviewed and in the Special Education/English Learner category five files were reviewed.

The principal, assistant principal, primary school scheduler, and secondary school scheduler were interviewed to gain an understanding of the student enrollment process.

The CPRB determined that LEHS is not in compliance with the CEA, Section III (b), Educational Services Branch policy that states, “Prior to arrival, all student’s files are screened for possible special education history. As students arrive at CEA high schools, there are assessed and enrolled into appropriate educational programs within four school days of their arrival.” The findings are as follows:

- English Learner Students are not all assigned to an appropriate educational program within four days of arrival.
- General Education Students are not all assigned to an appropriate educational program within four days of arrival.
- English Learner/Special Education Students are not all assigned to an appropriate educational program within four days of arrival.

BACKGROUND

The CPRB met with the Supervisor of Correctional Education Programs for the Division of Juvenile Justice Education Department (DJJED) on December 20, 2007. The purpose of the meeting and subsequent meetings with the DJJED was to discuss the peer review process, to identify high risk areas, and decide on the highest risk area to be evaluated during the peer review. Based on risk factor, it was determined that student enrollment within four days of arrival to his/her assigned facility would be reviewed.

Student Enrollment was selected for review because students that are not high school graduates are mandated to be enrolled in school per the DJJ Educational Manual, Sections 4065-4067, and the CEA, Section III (b). Additionally, student enrollment within four days has been a problem area for DJJ schools in the past.

The primary school scheduler adheres to the following procedure to ensure students are enrolled into an appropriate educational program within four days of arrival to his/her assigned facility: On a daily basis, the school scheduler conducts a query in the WIN to review the Daily Movement Roster for new ward arrivals. From that query, the school scheduler assigns the students to their classes.

The last formalized school scheduling training the primary school scheduler received was on October 18, 2007. The primary school scheduler indicated that he receives training semi-annually. The back-up school scheduler acquires training by obtaining copies of the policies and procedures.

The back-up school scheduler works part-time and assists the primary scheduler when he is off, on vacation, or in training.

The primary school scheduler has several other responsibilities that include; monitoring the Western Association of Schools and Colleges and the California High School Exit Exam. In addition, the primary school scheduler takes on miscellaneous responsibilities as the need arises.

An Associate Governmental Program Analyst (AGPA) position and a Management Services Technician position have been appropriated to LEHS to accommodate the workload demands concerning the scheduling. However, the AGPA is currently out on a medical leave of absence.

On March 28, 2008, LEHS implemented a local operating procedure to enroll students within three school days of their arrival to HGSYCF. Prior to the implementation date, LEHS enrolled new ward arrivals on Mondays only. This was done by the request of

staff to reduce the amount of student enrollment movements. The CPRB's review period was August 2007 through January 2008, and the new operating procedure went into effect on March 28, 2008. At the time of the review, the new operating procedure had been in existence for approximately one month; therefore the CPRB could not obtain an accurate analysis on the effectiveness of the new four day enrollment operating procedure.

The specific objectives of the review were to determine whether:

- HGSYCF is enrolling students into classes within four days of arrival to their assigned facility.

- HGSYCF has a written educational operating policy to address student enrollment within four days of arrival to their assigned facility.

FINDINGS AND RECOMMENDATIONS

Finding I: English Learner Students are not all assigned to school within four days of arrival.

Two out of ten (20 percent) English Learner files did not meet the criteria for enrolling wards into an appropriate educational program within four school days of arrival to the institution.

Criteria:

The Education Services Branch of the CEA states the following in Section III (b) of the Student Access Attendance: "As students arrive at CEA high schools, they are assessed and enrolled into appropriate educational programs within four school days of their arrival."

Recommendation:

Develop a monitoring system to accurately ensure students are enrolled into school within four days of arrival.

Finding II: General Education Students are not all assigned to school within four days of arrival.

Two out of ten (20 percent) General Education files did not meet the criteria for enrolling wards into an appropriate educational program within four school days of arrival to the institution.

Criteria:

The Education Services Branch of the CEA states the following in Section III (b) of the Student Access Attendance: "As students arrive at CEA high schools, they are assessed and enrolled into appropriate educational programs within four school days of their arrival."

Recommendation:

Develop a monitoring system to accurately ensure students are enrolled into school within four days of arrival.

Finding III: English Learner/Special Education Students are not all assigned to school within four days of arrival.

Two out of five (40 percent) English Learner/Special Education files did not meet the criteria for enrolling wards into an appropriate educational program within four days of arrival to the institution.

Criteria:

The Education Services Branch of the CEA states the following in Section III (b) of the Student Access Attendance: "As students arrive at CEA high schools, they are assessed and enrolled into appropriate educational programs within four school days of their arrival."

Recommendation:

Develop a monitoring system to accurately ensure students are enrolled into school within four days of arrival.

Review of Student Enrollment

HEMAN G. STARK YOUTH CORRECTIONAL FACILITY

GLOSSARY

AGPA	Associate Governmental Program Analyst
CEA	California Education Authority
CPRB	Compliance/Peer Review Branch
DJJ	Division of Juvenile Justice
DJJED	Division of Juvenile Justice Education Department
HGSYCF	Heman G. Stark Youth Correctional Facility
LEHS	Lyle Egan High School
WIN	Ward Information Network

COMPLIANCE PEER REVIEW

HEMAN G. STARK YOUTH CORRECTIONAL FACILITY

Prepared by:

California Department of Corrections and Rehabilitation
Office of Audits and Compliance

Preliminary Report

April 2008

HEALTH CARE SERVICES REQUEST FORMS

Institutions and Camps Manual, Sections 6169, 6255, and Revision IT-46, Section 6249.9.

Office of Audits and Compliance Staff
Karen Jennings, Team Treatment Supervisor
Shawn Jones-Burn, Senior Psychologist

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EXECUTIVE SUMMARY

The Office of Audits and Compliance, Compliance/Peer Review Branch (CPRB) reviewed the Institution and Camps Branch Manual (I&C Manual), Sections 6169, 6255, and Revision IT-46, Section 6249.9 to determine whether Heman G. Stark Youth Correctional Facility (HGSYCF) is in compliance with the policies that identify the responsibilities of health care staff for treating, evaluating, and tracking wards that request mental health services by submitting a Health Care Services Request form, Division of Juvenile Justice (DJJ) 8.018.

The review period was October 1, 2007 through March 31, 2008. During this period, the CPRB reviewed the Health Care Services Request Tracking log and found a total of 100 Health Care Services Requests submitted by wards in need of mental health services. The CPRB chose a 10 percent sample of wards requesting mental health services. Therefore, ten wards and their Unified Health Records (UHR) were reviewed. Of the ten wards selected, two submitted multiple requests. As a result, the CPRB reviewed 10 UHRs and 14 Health Care Services Request forms.

The CPRB determined that HGSYCF is not in compliance with the I&C Manual, Sections 6169, 6255, and Revision IT-46, Section 6249.9. The findings are as follows:

- Missing Health Care Services Request forms.
- Lack of documentation.
- Improper format.
- Health Care Services Request forms not properly completed.
- Data missing from the Health Care Services Request Tracking log.

BACKGROUND

In December 2005 an audit report was prepared by the Office of the Inspector General (OIG) documenting a ward's request for mental health services through the Health Care Services Request form. On four different occasions while assigned to Preston Youth Correctional Facility (PYCF), a ward requested mental health services. The ward's requests began in October 2004 and concluded in December 2004. Despite numerous requests, the ward never received treatment. One of the requests contained documentation by staff that the ward did not want to be seen. Follow up was not indicated by a psychologist or psychiatrist.

In March 2005, the ward was transferred to N. A. Chaderjian Youth Correctional Facility (NACYCF). There was no indication in the UHR that the ward requested mental health services on four separate occasions. The ward was classified as a low suicide risk. The ward was assigned to an intake hall and eventually transferred to a general population hall. The ward did not receive proper intervention from his earlier requests, while assigned to PYCF.

While the ward was assigned to NACYCF, there was no documentation that the ward continued to request mental health intervention. In July 2005, the ward's hall went on lock down due to a serious staff assault. In August 2005, the ward successfully committed suicide.

As a result, the CPRB determined that the procedures for requesting mental health intervention by way of the Health Care Services Request form should be reviewed. The review will help to ensure that all wards who request mental health services by submitting a Health Care Services Request form will receive treatment and the intervention will be documented.

HGSYCF has a monthly Mental Health Crisis schedule for all staff to follow. Staff concerned about wards that appear to be in need of immediate Mental Health intervention are to contact the on call Mental Health Staff. This procedure is a safeguard to ensure that wards who are in crisis, receive the necessary assistance by Mental Health staff.

The specific objectives of the review were to determine whether:

- The Health Care Services Request forms are being processed according to the I&C Manual, Revision IT-46, Sections 6169, and 6255;
- Health Care staff is collecting the Health Care Services Request forms daily;
- Health Care Services Request forms are filed in the ward's UHR;
- Each form is signed and dated when they are collected, and entered on the Health Care Services Request Tracking log, DJJ 8.017; and

- The Registered Nurse (RN) reviews all requests including signing, dating, and placing the time in the designated areas.

The RN is prioritizing the requests by the following methods:

- Urgent requests shall be seen the day of the request;
- Routine requests shall be seen within one business day of the request; and
- Requests for mental health care may be referred to mental health services, if available within the time limits of urgent or routine priority.

Weekends and Holidays

- The health care staff is delivering all forms to the Outpatient Housing Unit (OHU) RN or designee on weekends and holidays after entering the form on the Health Care Services Request Tracking Log.

The OHU RN or designee shall:

- Review the form for mental health needs and establish priorities for each request on an urgent or routine basis;
- Sign, date, and time stamp the forms in the designated areas;
- Determine whether urgent conditions relating to mental health should be reported to the appropriate on site psychiatrist;
- The night before the next scheduled clinic, all routine requests shall be returned to the appropriate medical clinic for scheduling and to the appropriate mental health staff member for collection;
- Psychologists/Psychiatrists are providing treatment to the wards making the requests. (Revision IT-46, Section 6249.9);
- Psychologists/Psychiatrists are placing documentation in the UHR that appropriate care has been delivered. (I&C Manual, Section 6255); and
- Psychologists/Psychiatrists are completing a brief note including the date, signature, and time stamp in the Chronological Record of Medical Care using the Subjective Objective Assessment Plan (SOAP) format. (I&C Manual, Section 6169 and 6255).

The CPRB determined whether the objectives were met by reviewing:

- The I&C Manual, Sections 6169 and 6255, Revision IT-46; Temporary Departmental Orders; and the facilities operational manuals.
- The audit report prepared by the OIG; Special Review into the Death of a Ward on August 31, 2005 at NACYCF, December 2005;

- Health Care Services Request forms relating to mental health;
- Health Care Services Request Tracking logs during the period of October 1, 2007 through March 31, 2008;
- UHRs;
- Information obtained from interviews with health care staff members; and
- The Ward Information Network (WIN) system data.

FINDINGS AND RECOMMENDATIONS

Finding I: Missing Health Care Services Request forms.

Of the fourteen Health Care Services Request forms reviewed, two (14 percent) were not in the UHRs. As a result, only 12 Health Care Services Request forms could be reviewed.

Criteria:

Revision IT-46 states: "All Health Care Services Request forms shall be filed in the UHR."

HGSYCF Health Care Services Local Operating Procedures. (It is the same as the Revision IT-46).

Recommendations:

Develop a standardized area in the UHR where the Health Care Services Request form is to be filed.

Amend HGSYCF Health Care Services Local Operating Procedures to specify where to place the Health Care Services Request forms.

Provide formal training to Health Care Staff regarding the proper filing of Health Care Services Request forms.

Finding II: Lack of documentation.

Of the 14 Health Care Services Request forms submitted for Mental Health, there was no documentation that four (29 percent) of the requests were evaluated by the psychiatrist/psychologist.

The CPRB reviewed the Mental Health section of the UHR and the WIN system to verify that the wards were seen by the psychiatrist/psychologist. As a result, the CPRB could not locate any documentation that the four wards who submitted Health Care Services Request forms were evaluated by the psychiatrist/psychologist.

Criteria:

I&C Manual, Section 6255, states: "The UHR is the official and chronological record of mental health treatment. The UHR shall be used as the primary record to document that appropriate care has been delivered."

- Clinical health services staff shall complete a brief note including the date, signature, and time stamp in the Chronological Record of Medical Care that draws attention to the filed document;

- Record changes in a ward's behavior, mental health status, mental health treatment, or program design in a timely fashion;

- Describe the problem and/or present event, observations, clinical assessment, planned care, and anticipated results;

- Use the SOAP format for recording, as outlined in the I&C Manual, Section 6169, UHR;

- Record summaries of individual interactions, group mental health interactions, and program progress; and

- Note the date and time of all UHR entries and sign above a printed name stamp.

Recommendation:

Provide formal training to all psychiatrists/psychologists on the proper method for documenting that care has been delivered.

Finding III: Improper format.

The psychiatrist/psychologist did not use the required SOAP format on one of the ten (ten percent) records of documentation that was filed in the UHR.

Of the ten records of documentation reviewed, one (ten percent) did not include the changes in the ward's behavior and the psychiatrist/psychologist did not use the required SOAP format. The review team determined the psychiatrist/psychologist reviewed the file and did not meet with the ward.

Criteria:

I&C Manual, Section 6255, states: "The UHR is the official and chronological record of mental health treatment. The UHR shall be used as the primary record to document that appropriate care has been delivered."

- Clinical health services staff shall complete a brief note including the date, signature, and time stamp in the Chronological Record of Medical Care that draws attention to the filed document;

- Record changes in a ward's behavior, mental health status, mental health treatment, or program design in a timely fashion;

- Describe the problem and/or the present event, observations, clinical assessment, planned care, and anticipated results;

- Use the SOAP format for recording, as outlined in the I&C Manual, Section 6169, UHR;

- Record summaries of individual interactions, group mental health interactions, and program progress; and

- Note the date and time of all UHR entries and sign above a printed name stamp.

I&C Manual, Section 6169, states: SOAP form progress notes to include no less than the following information:

1. Date and time note written.
2. S=Subjective (symptomatic) information.
3. O=Objective (measurable, observable) information.
4. A=Assessment (interpretation or impression of current condition).
5. P=Plan of Treatment.
6. Physicians' orders.
7. Test reports, such as laboratory, radiology, and psychological.
8. Consultants' reports.
9. Nurses' notes.
10. Medication administration records.

Recommendation:

Provide formal training to all psychiatrists/psychologists on the SOAP format.

Finding IV: Health Care Services Request forms not properly completed.

The RN did not establish a priority level on eight of the twelve forms (67 percent) reviewed. The RN was not completing the lower portion of the form that addresses establishing a priority level.

The RN did not review, sign, or enter the date and time on four (33 percent) of the twelve Health Care Services Request forms reviewed.

Criteria:

Revision IT-46, states: "All requests shall be reviewed by an RN. The RN shall sign the forms and enter the date and time in the designated area."

The RN shall determine the priority of the request:

- Urgent requests shall be seen on the day of the request;

- Routine requests shall be seen within one business day of the request; and

- Requests for mental health care may be referred to mental health staff if available within the time limits of urgent or routine priority.

Recommendations:

Provide Nurses with assessment training.

Ensure all Health Care Staff follow Revision IT-46.

Finding V: Data missing from the Health Care Services Request Tracking Log.

Four out of 100 (4 percent) Health Care Services Request forms were not entered into the Health Care Services Request Tracking log.

After conducting interviews with staff, the CPRB determined that some of the Health Care Services Request forms are not being logged into the Health Care Services Request Tracking log. This is due to wards submitting the Health Care Services Request forms to different staff. Subsequently, the mental health staff evaluated the wards but the Health Care Services Request forms were not entered on the Health Care Services Request Tracking log.

The problem is attributed to staff and wards not following the proper procedure of placing the Health Care Services Request forms in the locked Sick Call box on the living unit. As a result, Health Care Services Request forms are filtering in to Health Care Services through various avenues and the forms are not being logged properly on the Heath Care Services Request Tracking log.

Criteria:

Revision IT-46, states: "Health care staff shall collect the Health Care Services Request forms daily. Each form shall be signed and dated at the time the forms are collected, and entered on Health Care Services Request Tracking Log, DJJ 8.017."

Recommendations:

Ensure all request forms are logged on the Health Care Services Request Tracking log.

Ensure all Health Care Staff follow the Standard Operating Policy, HGSYCF Local Operating Procedure.

Provide training to all staff to ensure awareness that the Health Care Services form must be logged by an RN on the Health Care Services Request Tracking Log.

HEMAN G. STARK YOUTH CORRECTIONAL FACILITY

GLOSSARY

CPRB	Compliance/Peer Review Branch
DJJ	Division of Juvenile Justice
I&C Manual	Institution and Camps Branch Manual
HGSYCF	Heman G. Stark Youth Correctional Facility
NACYCF	N. A. Chaderjian Youth Correctional Facility
OHU	Outpatient Housing Unit
OIG	The Office of the Inspector General
PYCF	Preston Youth Correctional Facility
RN	Registered Nurse
SOAP	Subjective Objective Assessment Plan
UHR	Unified Health Record
WIN	Ward Information Network

Information Security Compliance Review
Heman G. Stark Youth Correctional Facility
Exit Conference Discussion Notes
May 2, 2008

The Office of Audits and Compliance (OAC), Information Security Branch (ISB) conducted an Information Security Compliance Review of Heman G. Stark Youth Correctional Facility on April 29 and May 1, 2008. The review covered 14 different areas. Heman G. Stark Youth Correctional Facility was fully compliant in 10 areas and partially compliant in 4 areas. The overall score is 92%. The chart below details these outcomes.

FINDINGS SUMMARY:

		Score	Compliant	Partial Compliance	Non Compliant
STAFF COMPUTING ENVIRONMENT					
1.	Compliance E-mail Form is on file.	70%		PC	
2.	Annual Self-Certification of Information Security Awareness and Confidentiality forms are on file.	NA			
3.	Information security training is current.	NA			
4.	Staff log on are using own password.	100%	C		
5.	Network access authorization is on file.	96%	C		
6.	Physical locations of CPUs agree to inventory records.	76%		PC	
7.	Staff CPUs labeled “No Inmate Access.”	N/A			
8.	Staff monitors are not visible to inmates.	100%	C		
9.	Anti virus updates are current.	81%		PC	
10.	Security patches are current.	90%	C		
WARD COMPUTING ENVIRONMENT (Education, Library, Clerks)					
11.	Physical location of CPUs agrees to inventory records	100%	C		
12.	CPU labeled as ward computer.	100%	C		
13.	Anti virus updates are current.	N/A			
14.	Ward monitors are visible to supervisor.	100%	C		
15.	Portable media is controlled.	100%	C		
16.	Telecommunications access is restricted.	100%	C		
17.	Operating system access is restricted.	80%		PC	
18.	Printer access is restricted.	100%	C		
	Total of Tests		10	4	0
	Overall Percentage	**92%**			

Please Note:

1. Tests marked with “N/A” were not tested due to the differences between adult and youth policies. There are no youth policies for these tests, and therefore the tests were not performed.

Information Security Compliance Review
Heman G. Stark Youth Correctional Facility
Exit Conference Discussion Notes
May 2, 2008

OBJECTIVES, SCOPE, AND METHODOLOGY

The objectives of the Information Security Compliance Review were to:

- Assess compliance to selected information security requirements,
- Evaluate other conditions discovered during the course of fieldwork that may jeopardize the security of information assets of the facility or of the Department, and
- Provide information security training for management and staff.

In conducting the fieldwork the ISB performed the following procedures:

- Interviewed senior management, information technology staff, institutional staff, and computer users.
- Asked staff to provide evidence that all authorized computer users had Acceptable Use Agreement forms and appropriate training support documentation on file.
- Tested selected information security attributes of users and IT equipment using three different population samples. This included both the staff and inmate computing environments.
- Reviewed various laws, policies and procedures, and other criteria related to information security in the custody environment.
- Conducted physical and remote inspections of selected computers.
- Observed the activities of the information technology support staff.
- Analyzed the information gathered through the above processes and formulated conclusions.

FINDINGS AND RECOMMENDATIONS

The ISB provided a copy of our review guide to your IT staff. It contains criteria and detailed methodology. That information, therefore, is not duplicated under each finding.

ISB's findings and recommendations are listed below. ISB staff discussed them with management in an exit conference following our fieldwork. Please contact us if you would like to discuss further any of these issues.

Information Security Compliance Review
Heman G. Stark Youth Correctional Facility
Exit Conference Discussion Notes
May 2, 2008

1. **The Computing Technology Use Agreements (Form 1857) or the Division of Juvenile Justice (DJJ) equivalents are not on file for all computer users. (70% compliance)**

   Recommendation: Require all users (staff and contractors) to complete a Form 1857 or the DJJ equivalent before being granted computer access. (Youth Authority Manual, Temporary Departmental Order 7250-Compliance Form, and Department Operations Manual (DOM) 48010.8, 48010.8.2)

2. **Physical locations of staff computers do not agree to inventory records. (76% compliance)**

   Recommendation: Maintain accurate inventory records. Evaluate procedures and resources used to maintain inventory records. (Institution and Camps Branch Manual (I&C Manual)) 1720, and DOM 46030.1, 49010.4)

3. **All Staff computers did not have up-to-date antivirus software. (81% compliance).**

   Recommendation: Update antivirus software on all staff computers. (State Administrative Manual 4840, and DOM 48010.9)

4. **All ward access to computer operating systems must be restricted. (80% compliance)**

   Recommendation: Restrict ward access to computer Operating System files.
   (I&C Manual 1725, I&C Manual 1910, I&C Manual 5040, and DOM 49020.18.3)

State of California Department of Corrections and Rehabilitation

Memorandum

Date :

To : Ramon Martinez
Superintendent (A)
Heman G. Stark Youth Correctional facility

Subject: **PRELIMINARY AUDIT REPORT OF THE PLANT OPERATIONS-HEMAN G. STARK YOUTH CORRECTIONAL FACILITY**

Attached is the Preliminary Audit Report of Findings and Recommendations developed during the audit of Plant Operations at Heman G. Stark Youth Correctional Facility. The Office of Audits Compliance (OAC), Audits Branch conducted the fieldwork during the period of April 28 through May 2, 2008. A complete description of each finding, its impact, criteria and recommendation is contained within the narrative portion of the report.

There are 15 findings identified in the preliminary report categorized under the topics of Safety and Security, Policies, Plans and Procedures, Health and Safety, Late Detection and Additional Workload, Training, and Internal Control.

Please provide, within 45 days, a brief description of your Corrective Action Plan (CAP) for each finding and a date when you expect the finding to be resolved. The OAC will issue a final report within 60 days after receipt of your CAP.

A follow-up audit will be scheduled as deemed necessary. Should you have any specific questions, please contact René Francis at (916) 255-2944 or Michael Robinson at (916) 255-2666. For general information call Patricia Weatherspoon at (916) 255-2729.

RICHARD C. KRUPP, Ph.D.
Assistant Secretary
Office of Audits and Compliance

Attachment

cc: René Francis, OAC
Patricia Weatherspoon, OAC

CALIFORNIA DEPARTMENT OF CORRECTIONS AND REHABILITATION
OFFICE OF AUDITS AND COMPLIANCE

REPORT OF FINDINGS AND RECOMMENDATIONS

PLANT OPERATIONS

HEMAN G. STARK
YOUTH CORRECTIONAL FACILITY

APRIL 28 – MAY 2, 2008

PRELIMINARY

CONDUCTED BY

THE AUDITS BRANCH

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OFFICE OF AUDITS AND COMPLIANCE
AUDITS BRANCH

HEMAN STARKS G. YOUTH CORRECTIONAL FACILITY

INTRODUCTION

The California Department of Corrections and Rehabilitation's (CDCR), Office of Audits and Compliance (OAC), Audits Branch conducted an audit of Plant Operations at Heman G. Stark Youth Correctional Facility (HGSYCF). The purpose of the audit was to analyze and evaluate the level of compliance with State and departmental policies, procedures, rules, regulations, operational objectives, and guidelines. The policies, procedures and guidelines consisted of The Youth Administrative Manual (YAM). The Institution and Camps Branch Manual (I&C Manual), The California Code of Regulations (CCR), the Penal Code, General Industrial Safety Orders (GISO), the Departmental Plant Operations Maintenance Procedural Manual (DPOMPM) and the California Department of Health Service (DHS) Environmental Health Surveys.

The following areas within Plant Operations were audited:

- Organizational Charts, Mission and Duty Statements;
- Communication/Performance Evaluations;
- Policies and Procedures;
- Inspection of Facilities, Systems and Equipment;
- Training Plans;
- Life, Health and Safety Management;
- Warehousing and Inventory Control;
- Hazardous Material Handling;
- Tool Control;
- Work Orders;
- Preventive Maintenance;
- Space Management;
- Construction Activity;
- Utilities; and
- Fiscal Management;

The fieldwork was performed during the period of April 28 through May 2, 2008. The exit conference was held on May 2, 2008.

René Francis, Certified Government Financial Manager, supervised the audit. Management Auditors, Annette Sierra and Michael Robinson conducted the audit. Patricia Weatherspoon, Senior Management Auditor, provided second line supervision, management and review. Richard C. Krupp, Assistant Secretary of OAC, provided executive management oversight.

The audit consisted of an entrance conference, review of the prior audits, test of transactions, interviews, observations, briefings, an exit conference, and issuance of the preliminary audit report.

OFFICE OF AUDITS AND COMPLIANCE
AUDITS BRANCH

Heman G. Stark Youth Correctional Facility

AUDIT SCOPE

The scope of the audit encompasses the examination and evaluation of the adequacy and effectiveness of HGSYCF system of management control and compliance to applicable policies, procedures, rules, and regulations. The audit period may include prior fiscal years if deemed necessary. The control objectives include, but are not limited to the following:

- State assets are safeguarded from unauthorized use or disposition;
- Transactions are executed in accordance to management's authorizations;
- Transactions are executed in accordance with applicable rules and regulations;
- Transactions are recorded correctly to permit the preparation of financial and management reports; and
- Programs are working efficiently and effectively.

In order to determine the adequacy of the control systems and level of compliance with State, federal, and departmental fiscal procedures, the audit team performed the following audit procedures:

- Examined evidence on a test basis supporting management's assertions;
- Performed detailed analyses of documentation and transactions;
- Interviewed Facility staff;
- Made inspections and observations;
- Performed group discussions of the overall impact of deficiencies; and
- Discussed deficiencies with supervisors and management throughout the audit process.

SYMPTOMS OF CONTROL DEFICIENCIES

Experience has indicated that the existence of one or more of the following danger signals will usually be indicative of a poorly maintained or vulnerable control system. These symptoms may apply to the organization as a whole or to individual units or activities. Department heads and managers should identify and make the necessary corrections when warned by any of the danger signals listed below:

- Policy and procedural or operational manuals are either not currently maintained or are nonexistent;
- Lines of organizational authority and responsibility are not clearly articulated or are nonexistent;
- Financial and operational reporting is not timely and is not used as an effective management tool;
- Line supervisors ignore or do not adequately monitor control compliance;
- No procedures are established to assure that controls in all areas of operation are evaluated on a reasonable and timely basis;
- Internal control weaknesses detected are not acted upon in a timely fashion; and
- Controls and/or control evaluations bear little relationship to organizational exposure to risk of loss or resources.

OFFICE OF AUDITS AND COMPLIANCE
AUDITS BRANCH

Heman G. Stark Youth Correctional Facility

EXECUTIVE SUMMARY

The Audits Branch (AB) conducted an audit of the Plant Operations at HGSYCF from April 28 through May 2, 2008. The purpose of the audit was to determine the level of compliance with State, federal, and departmental rules, regulations, policies, and procedures.

The policies, procedures and guidelines consisted of The Youth Administrative Manual (YAM). The Institution and Camps Branch Manual (I&C Manual), The California Code of Regulations (CCR), the Penal Code, General Industrial Safety Orders (GISO), the Departmental Plant Operations Maintenance Procedural Manual (DPOMPM) and the California Department of Health Service (DHS) Environmental Health Surveys.

The exit conference was held on May 2, 2008. The AB requested that HGSYCF provide a CAP within 45 days of receipt of the preliminary audit report.

Areas audited:

- Organizational Charts, Mission and Duty Statements;
- Communication/Performance Evaluations;
- Policies and Procedures;
- Inspection of Facilities, Systems and Equipment;
- Training Plans;
- Life, Health and Safety Management;
- Warehousing and Inventory Control;
- Hazardous Material Handling;
- Tool Control;
- Work Orders;
- Preventive Maintenance;
- Space Management;
- Construction Activity;
- Utilities; and
- Fiscal Management;

Fifteen findings are identified in the preliminary audit report, categorized under the following topics:

Category	Number of Findings	Page Number
Safety and Security	1	1
Policies, Plans, and Procedures	6	2
Health and Safety	2	5
Late Detection and Additional Workload	4	7
Training	1	9
Internal Control	1	10
Total	**15**	

I. SAFETY AND SECURITY

1. Tool Control

The Boiler House, Motor pool and Paint Shop were reviewed to determine the level of compliance with the tool control policies stated in the CCR and the I&C Manual. Four deficiencies were identified in the Boiler House, three deficiencies were identified in the Motor Pool as well as the Paint Shop. Common to all three areas is that the master inventory does not reconcile with the shadow boards or the tool box.

Impact: This issue could result in late detection of missing tools.

II. POLICIES, PLANS AND PROCEDURES

The emergency preparedness plan for plant operations is not up-to-date and user friendly. The names of the current Chief of Plant Operations (CPO) and the Business Manager (BM) are incorrect and the index is alphabetical but the tabs are numerical. CCR, Title 15.

Impact: This issue could result in difficulty responding to emergencies.

The written Respiratory Protection Program (RPP) were not updated, reviewed, and approved in over 5 years based on best available information. General Industrial Safety Orders (GISO)

Impact: This issue could result in difficulty identifying worksite-specific procedures and elements required for respiratory use.

There is no approved operating procedure for the Control of Dangerous and Toxic Substances. CCR Title 8.

Impact: This issue could result in difficulty maintaining a working and living area that is free as possible from unsafe and unhealthy exposure.

An Operational Procedure for the work order system, that impacts the entire institution, was not established. CCR, Title 15 sub-chapter 5, article 1 3380 (c).

Impact: This issue could result in difficulty implementing an efficient work order system.

A formalized Confined Space Program was not established, developed, and implemented. CCR, Title 8, Article 108 5157 (F).

Impact: This issue could result in employees not being adequately trained and knowledgeable in the skills necessary for safe access to confined space.

There was no development and implementation of a written preventive maintenance plan based on the guidelines established by CDCR's Facility Maintenance. CCR Title 15.

Impact: This issue could result in employees not following current policies and procedures related to performing preventive maintenance.

III. HEALTH AND SAFETY

The AB noted deficiencies regarding the Hazardous Communication Program at the Boiler House, Motor Pool and the Paint Shop. A common deficiency found at all three locations is that a daily perpetual inventory of chemicals is not conducted and labels may contain incorrect information. CCR, Title 8.

Impact: This results in an increased threat to life, health and safety.

Safety meetings (i.e. tailgates) are not conducted at least once every ten days and documented. CCR Title 8

Impact: Employees may not perform their duties in a safe and healthful manner.

IV. LATE DETECTION AND ADDITIONAL WORKLOAD

The Chief of Plant Operations (CPO) or designee does not review and document inspections on a regular basis. CCR, Title 15.

Impact: This issue could result in late detection of problems.

Work order priorities are not established in accordance with departmental guidelines. Also, time and materials are not documented on work orders. CCR Title 15.

Impact: This issue could result in work orders not being completed in a timely manner and difficulties determining the length of time and cost of performing a task.

Preventive maintenance (PM) of equipment is not performed and documented. Departmental Plant Operations Maintenance Procedures Manual (DPOMPM)

Impact: This issue could result in late detection of equipment problems, decrease efficiency, increase downtime and incurring additional cost due to repairs.

The CPO or selected key staff are not assigned to a facility wide committee that has an impact on maintenance and other plant responsibilities, such as a space utilization committee. Also, space action request are not used. YAM, 9400.

Impact: This issue could result in difficulty accomplishing the goals and objectives of the institution space management.

V. TRAINING

There is no suitably trained program administrator to manage the Respiratory Protection Program. .CCR, Title 8 and the General Industrial Safety Orders (GISO).

Impact: This issue could result in the inappropriate use of respiratory equipment.

VI. INTERNAL CONTROL

Separation of duties at the Maintenance Warehouse is insufficient. SAM 20050.

Impact: This issue may result in late detection of errors, irregularities and/or misappropriations.

FINDINGS AND RECOMMENDATIONS

I. SAFETY AND SECURITY

1. Tool Control

Control over tools is inadequate. The AB noted deficiencies in the following areas:

BOILER HOUSE

- Tools were removed from the shadow boards without the use of chits.
- Tools not in use were lying on a shelf.
- Not all tools maintained on the shadow board have a shadow.
- The master inventory listing does reconcile to the shadow board.

MOTOR POOL (auto shop)

- According to the tool inventory, an inventory was not conducted before the beginning of the shift on April 30, 2008.
- The master inventory listing does reconcile to the tool box and shadow boards are not used.
- Staff certifies the inventory without knowing the quantity of tools that are to be certified.

PAINT SHOP

- All tools are not stored in the designated tool room.
- The master inventory listing does not reconcile to the shadow board.
- Grab buckets (this includes rollers, strainers, etc.) are not included on inventory.

This issue could result in late detection of missing tools.

This is not in accordance to the I&C Manual section 1821 that states “each facility shall have detail written policy on tool control for all areas of the institution.” CCR Title 15 section 3303 states in part institution heads shall maintain procedures for controlling the following safety and security hazards within facilities. . . control of tools”

Recommendation

Review the current policies and procedures related to tool control. Determine which ones apply to HGSYCF and develop a plan/strategy to ensure that tool control is administered in accordance with applicable policies and procedures.

II. POLICIES, PLANS AND PROCEDURES

1. Emergency Preparedness Plan

The emergency preparedness plan is not up-to-date and user friendly. The names of the current CPO and the BM are incorrect, and the index is alphabetical but the tabs are numerical.

This issue could result in difficulty responding to emergencies.

CCR Title 15, article 4 Section 3302: "Emergency Preparedness Plan requires in part that (a) Each warden and superintendent must have in effect at all times a plan approved by the director for meeting emergencies delineated and required by the California Emergency Services Act of 1970 (b) This plan will include, as a minimum, emergency measures to be taken to prepare for and respond to the following types of emergency situations: (1) War. (2) Earthquakes. (3) Seismic sea waves; (4) Flood; (5) Fire; (6) Civil Disturbances; (7) Accident, transportation-industrial, and; (8) Pollution (c) a separate Employee Protection Plan will be developed in accordance with the California Emergency Services Act. Two copies of this plan will be attached to the emergency preparedness plan when that plan is submitted to the director for approval (d) Emergency preparedness plans and the employee protection plan will be revised and updated by the warden or superintendent and be submitted to the director for approval biennially."

Recommendation

Review the Emergency Preparedness Plan, update as necessary and distribute the plan in accordance with the CCR.

2. Respiratory Protection Program

The written Respiratory Protection Program was not updated, reviewed, and approved in over 5 years.

This issue could result in difficulty identifying worksite-specific procedures and elements for required respiratory use.

Subchapter 7, General Industry Safety Orders, Group 16 Control of Hazardous Substances, Article 107, Dusts, Fumes, Mist, Vapors and Gases. (c) Respiratory Protection Program requires in part the following; “This subsection requires the employer to develop and implement a written respiratory protection program with required worksite-specific procedures and elements for required respirator use.”

Recommendation

Review the Respiratory Protection Program and update as necessary.

3. Hazardous Communication Program

There is no approved OP for the Control of Dangerous and Toxic Substances.

This issue could result in difficulty maintaining a working and living area that is free as possible from unsafe and unhealthy exposure.

CCR Title 15, Section 3303 (b) states in part “Institution heads shall maintain procedures for controlling the following safety and security hazards within the facility: Control of harmful physical agents and toxic or hazardous substances. CCR, Title 15 sub-chapter 5. Article 1 3380(c), Subject to the approval of the Wardens, Superintendents and parole region administrators will establish such operational plans and procedures as are required for implementation of regulations and as may otherwise be required for their respective operations . . .such procedures will apply only to the inmates, parolees, and personnel under the administrator.”

Recommendation

Develop an OP that provides guidance related to handling, controlling, safeguarding, and dispensing of dangerous and toxic substances.

4. Work Orders

An OP for the work order system that impacts the entire institution was not established.

This issue could result in difficulty implementing an efficient work order system.

CCR, Title 15 sub-chapter 5. Article 1 3380(c), “Subject to the approval of the Wardens, Superintendents and parole region administrators will establish such operational plans and procedures as are required for implementation of regulations and as may otherwise be required for their respective operations . . .such procedures will apply only to the inmates, parolees, and personnel under the administrator.”

Recommendation

Develop a Local OP that establishes guidelines for an orderly and standard method of processing and accomplishing the services requested of the Plant Operations.

5. Confined Space Program

A formalized Confined Space Program was not established, developed and implemented.

This issue could result in employees not being adequately trained and knowledgeable in the skills necessary for safe access to confined space.

CCR, Title 8, Article 108 5157(F), states in part (1) “The employer shall evaluate the workplace to determine if any spaces are permit-required confined spaces. Note: Proper application of the decision flow chart in Appendix A would facilitate compliance with this requirement.” (2) “If the workplace contains permit spaces, the employer shall inform exposed employees and other employees performing work in the area, by posting danger signs or by any other equally effective means, of the existence, location of and the danger posed by the permit spaces. Note: A sign reading "DANGER -- PERMIT-REQUIRED CONFINED SPACE, DO NOT ENTER" or using other similar language would satisfy the requirement for a sign.” (3) “If the employer decides that its employees and other employees performing work in the area will not enter permit spaces, the employer shall take effective measures to prevent all such employees from entering the permit spaces and shall comply with subsections (c)(1), (c)(2), (c)(6), and (c)(8).” (4) “If the employer decides that its employees will enter permit spaces, the employer shall develop and implement a written permit space program that complies with this section. The written program shall be available for inspection by employees and their authorized representatives.” DOM Supplement 32010.5, states in part, “Job required training is designed to assure adequate performance in a current assignment . . . Employees must receive training in confined space operations at least once per year . . . .”

Recommendation

Develop an OP that provides guidelines related to safe access of confined spaces.

6. Preventive Maintenance

There was no development and implementation of a written preventive maintenance plan based on the guidelines established by CDCR’s Facility Maintenance.

This issue could result in employees not following current policies and procedures related to performing preventive maintenance.

The CCR, Title 15 sub-chapter 5 Article 1 3380(C), states in part "Subject to the approval of the Wardens, Superintendents and parole region administrators will establish such operational plans and procedures as are required for implementation of regulations and as may otherwise be required for their respective operations . . . such procedures will apply only to the inmates, parolees, and personnel under the administrator."

Recommendation

Obtain Departmental Guidelines for PM's. Develop a written procedure based on those guidelines as well as local needs which ensure that PM's is properly performed.

III. HEALTH AND SAFETY

1. Hazardous Communication Program

Plant Operations is not maintaining chemicals properly. The AB noted deficiencies at the following locations regarding the Hazardous Communication Program (HCP):

Boiler House:

- MSDS are not maintained for chemicals stored and used.
- A daily perpetual chemical inventory is not conducted.
- A flammable chemical (Phenolphthalein) is maintained in a wooden cabinet.
- Chemicals are sitting on top of each cabinet which may cause a chemical reaction, if there is a leak.
- Chemicals are maintained without labels and placed on the floor.
- Formula 310 and 318 which is hazardous to humans and animals is maintained on a wooden pallet instead of secondary containment and stored in inclement weather.

Motor pool (auto shop):

- Hazardous waste labels (HWL) do not reflect accurate or correct accumulation start dates (ASD).
- HWL are illegible.
- Oily rags are not maintained appropriately in a hazardous waste container. They are maintained outside on the ground.

- A daily perpetual chemical inventory is not conducted.

Paint shop:

- Hazardous waste does have an ASD.
- Hazardous waste is maintained on a wooden pallet instead of secondary containment.
- Inappropriate secondary containers are used without labels, such as licorice containers.
- A daily perpetual chemical inventory is not conducted.

This results in an increased threat to life, health and safety.

The CCR, Title 8, Section 5194 HCP states in part, "Department heads shall monitor daily compliance with this procedure in the areas of their responsibility . . . Each area supervisor shall ensure that every person required to work with or use hazardous, toxic, volatile substances is appropriately trained ". CCR Title 15, 3303 (b) states in part "Institution heads shall maintain procedures for controlling the following safety and security hazards within the facility: Control of harmful physical agents and toxic or hazardous substances.

Recommendation

Review the deficiencies listed above, provide training and perform spot checks periodically to determine whether Plant Operations staff is complying with the policies and procedures governing the control of chemicals.

2. Safety Meetings

Safety meetings (i.e. tailgates) are not conducted for each maintenance section at least every 10 days and written minutes were not taken for one hundred percent of the shops tested, staff did not conduct and document consistent safety meetings.

This issue can result in employees not performing their duties in a safe and healthful manner.

CCR, Title 8, Article 3 section 8406(e) IIPP states in part "supervisory personnel shall conduct "toolbox" or "tailgate" safety meetings with their crews at least weekly on the job to emphasize safety. A record of such meetings shall be kept, stating the meeting date, time, place, supervisory personnel present subjects discussed and corrective action taken, if any, and maintained for inspection."

Recommendation

Conduct safety meetings (i.e. tailgates) on a weekly basis and prepare documentation to support that safety meetings are conducted in the time frames established by the CCR.

IV. LATE DETECTION AND ADDITIONAL WORKLOAD

1. Inspections

The CPO or designee does not inspect and document inspections on a regular basis.

This issue could result in late detection of problems.

CCR, Title 15, 1280 states: "The facility administrator shall develop written policies and procedures for the maintenance of an acceptable level of cleanliness, repair and safety throughout the facility. Such a plan shall provide for a regular schedule of house keeping task and inspections to identify and correct unsanitary or unsafe conditions or work practices which may be found."

Recommendation

Perform and document periodic inspections of the facility to ensure that problems and irregularities are detected in a timely manner.

2. Work Orders

Work order priorities are not established in accordance with departmental guidelines. Additionally, staff/wards time and materials are not documented on work orders.

This issue could result in work orders not being completed in a timely manner and difficulty determining the length of time and cost of performing a task.

This condition is not in accordance with the CCR, Title 15 sub-chapter 5. Article 1 3380(C), "subject to the approval of the warden and superintendents and parole region administrators will establish such operational plans and procedures as are required for implementation of regulations and as may otherwise be required for their respective operations. . .such procedures will apply only to the imamates, parolees, and personnel under the administrator."

Recommendation

Review the departmental guidelines for establishing work order priorities. Remind plant operations staff of the requirement to properly complete work orders.

3. Preventive Maintenance

Preventive maintenance of equipment is not performed and documented.

PM is designed to provide systematic servicing, inspection and prevention of failure and abuse of facilities and equipment. It includes the proper care, use, operation, cleaning, preservation and lubrication of the facilities and equipment. Also, PM's include the inspection, adjustment, minor repairs and parts replacement necessary to eliminate incipient difficulties before they become major. During the review, the AB could not locate or were not provided historical asset data related to PM for the four facilities major systems as follows.

The mechanical equipment includes:

Heating/ventilating air handlers
Supply and return air fans
Air conditioning systems (compressors, condensers, coils and fans)
Cooling towers
Package air conditioning units
Unit ventilators and fan coil-units
Circulating pumps
Condensate return pumps
Lift and sump pumps
Unit pumps
Steam/hot water converters
Domestic water heaters
Air compressors
Vacuum pumps
Refrigeration
Boilers
Water Treatment systems

The electrical equipment includes:

Transformers
Switchgear
Motor control centers
Panel Boards (power, lighting)
Motor starters
Motors (as part of other units)
Emergency generators
Communication equipment
Alarm systems

This issue could result in late detection of equipment problems, decrease efficiency, increase downtime and additional cost of repairs.

DPOMPM, I-A states in part: “Wardens/Superintendents are responsible for the development and implementation of a written preventive maintenance plan based on the guidelines provided by Facilities Maintenance. . . Overall responsibility for the operation of this procedure shall be with the Correctional Administrator, Business Services, with functional responsibility delegated to the chief of Plant Operations. . .”

The CCR, Title 15 sub-chapter 5 Article 1 3380(C), states in part: “Subject to the approval of the Wardens, Superintendents, and parole region administrators will establish such operational plans and procedures as are required for implementation of regulations and as may otherwise be required for their respective operations . . . such procedures will apply only to the inmates, parolees, and personnel under the administrator.”

Recommendation

Establish a PM schedule for all major equipment. Determine the tasks that are to be performed and train staff as necessary to ensure proper performance of PM’s.

4. Space Utilization

The CPO or selected key staffs were not assigned to a facility wide committee that has an impact on maintenance and other plant responsibilities, such as a space utilization committee. In addition, space action requests were not used.

This issue could result in difficulty accomplishing the goals and objectives of the institution space management.

The Youth Authority Manual (YAM) 9400 which states “Staff shall follow procedures established herein to obtain space for new offices or programs; to renew leases for existing facilities; to propose alterations to existing facilities; or to obtain living facilities for the departments’ wards.”

Recommendation

Review the YAM policy and select employees to participate in a facility wide committee, such as the Space Utilization Committee.

V. TRAINING

There is no suitably trained program administrator to administer the Respiratory Protection Program (RPP).

This issue could result in the inappropriate use of respiratory equipment.

CCR Title 8 and the General Industrial Safety Orders (GISO). The program must be administered by a suitably trained program administrator. In addition, certain program elements may be required for voluntary use to prevent potential hazards associated with the use of the respirator. The Small Entity Compliance Guide contains criteria for the selection of a program administrator and a sample program that meets the requirements of this subsection.

Recommendation

Select an employee that is qualified to be trained as a public administrator to manager the Respiratory Protection Program.

VI. INTERNAL CONTROL

Separation of duties at the Maintenance Warehouse is insufficient. The one Material and Store Supervisor in charge of the warehouse has the following duties:

- Order supplies
- Receive supplies
- Maintain goods in inventory
- Process requisition
- Operate the inventory system

These five duties, in aggregate, constitute a significant control over inventory.

This issue may result in late detection of errors, irregularities and/or misappropriations.

SAM, Section 20050, states in part, "…the elements of a satisfactory system of internal accounting and administrative controls, shall include…A plan of organization that provide segregation of duties appropriate for proper safeguarding of state assets…."

Heman G. Stark, Youth Correctional Facility, Plant Operations, Maintenance Warehouse, Policy and Procedures Manual, [B] Functions and Typical Duties of M&SS I:, which states in part, "2) Assists customers in the areas of supplies issue, location of items, special requisitions, and materials transport. 3) In-checks and stock receives all items pertaining to Plant Operations. These include items received through UPS, direct shipment, US Mail, will-calls, and drop shipments. 7) Posts all receipts, issues, and inventory adjustments to the computer. . . "

Recommendation:

Establish a procedure to ensure that the Material and Store Supervisor has less control over inventory and monitor the process for compliance.

OFFICE OF AUDITS AND COMPLIANCE
AUDITS BRANCH

HEMAN G. STARK YOUTH CORRECTIONAL FACILITY

GLOSSARY

AB	Audit Branch
BM	Business Manager
CAP	Corrective Action Plan
CCR	California Code of Regulations
CDCR	California Department of Corrections and Rehabilitation
CPO	Chief of Plant Operation
DHS	Department of Health Service
DPOMPM	Departmental Plant Operations Maintenance Procedure Manual
GISO	General Industrial Safety Orders
HCP	Hazardous Communication Program
HGSYCF	Heman G. Stark Youth Correctional Facility
I&C	Institution and Camps Manual
OAC	Office of Audits and Compliance
OP	Operational Procedure
PM	Preventive Maintenance
RPP	Respiratory Protection Program
YAM	Youth Administrative Manual

COMPLIANCE PEER REVIEW

HEMAN G. STARK YOUTH CORRECTIONAL FACILITY

Prepared by:

California Department of Corrections and Rehabilitation
Office of Audits and Compliance

Preliminary Report

April 2008

USE OF FORCE

Division of Juvenile Justice, Temporary Departmental Order #06-73, Sections 2080-2107 - Use of Force

Office of Audits and Compliance Staff
Gil DeLyon, Captain
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EXECUTIVE SUMMARY

The Office of Audits and Compliance, Compliance/Peer Review Branch (CPRB) reviewed the Division of Juvenile Justice (DJJ), Temporary Departmental Order (TDO) 06-73, Sections 2080 through 2107, to determine whether Heman G. Stark Youth Correctional Facility (HGSYCF) is in compliance with the policy that identifies peace officer responsibilities for applying force, reporting force, and reporting excessive and/or, unnecessary force.

The review period for the Institutional Force Review Committee (IFRC) reports was October through November 2007. The CPRB identified a sample of 107 IFRC reports and as a result, the CPRB provided a critical analysis of 10 percent of the reports to be included in the review. The review period for staff use of force (UOF) inquiries was January 1 through December 31, 2007. The CPRB reviewed the Inquiry/Grievance Incident database and determined that HGSYCF had nine staff inquiries relating to UOF. The CPRB selected all 9 inquiries to be included in the review. The following were the findings:

The CPRB determined that HGSYCF is not in compliance with TDO 06-73, Sections 2102 and 2107.

- UOF packets not completed within time frames.
- Staff inquiries not completed within time frames.

BACKGROUND

The CPRB met with the DJJ on January 8, 2008, to discuss areas of high risk. UOF was identified as a high risk area, due to both past litigation and court mandates. Therefore, based on risk factor, the CPRB determined that UOF would be the topic of review. The review will help to ensure that all time frames are met and the UOF reports are accurately documented.

The specific objectives of the review were to determine whether:

- UOF is reviewed at a supervisory and managerial level, and the IFRC is meeting on a monthly basis. (TDO 06-73, Section 2085).

- Time frames have been met regarding all applicable reports, clarifications, and forms pertaining to the UOF report package. (TDO 06-73, Section 2102).

    a. Captain/Major – Normally within 2 business days of receipt.

    b. Superintendent - Normally within 2 business days of receipt.

    c. IFRC – To review within 30 days.

    d. Departmental Force Review Committee.

    e. Bureau of Independent Review.

- The UOF reports are maintained in a database and the length of time the reports are retained. (TDO 06-73, Section 2106).

- All inquiries regarding allegations of excessive or unnecessary force are assessed (no action needed, conduct an inquiry, or recommend a formal Internal Affairs investigation), and the reports are completed within the required time frames. Additionally, when an inquiry is not concluded in 30-days, the superintendent/site administrator shall request a 30-day extension through the chain of command to the Director of the Division of Juvenile Facilities. (TDO 06-73, Section 2107).

FINDINGS AND RECOMMENDATIONS

Finding I: UOF packets not completed within time frames.

Time frames for UOF packets, up to and including the Chief of Security, Superintendent, and the IFRC are not being completed within departmental time frames.

The CPRB conducted interviews and reviewed the IFRC UOF records to determine whether HGSYCF is completing the UOF packets within departmental time frames. During the period of October and November 2007, there were 107 IFRC UOF records. The CPRB reviewed ten percent for a total of 11 records.

According to the IFRC UOF records, none of the UOF packets were completed within departmental time frames for the 2007 review period.

Criteria:

TDO# 06-73, Section 2085, states in part: "All UOF shall be reviewed at a supervisory and managerial level," and "On at least a monthly basis, the IFRC shall meet to review all completed UOF incidents after critique by area managers."

TDO# 06-73, Section 2102, states in part: "The Chief of Security usually reviews the incident report package within 2 days;" and "The Superintendent usually reviews the incident report package within 2 days."

Recommendations:

The IFRC shall meet more than once a month.

Assign staff to track the IFRC UOF Records.

Provide training for staff regarding UOF reports, clarifications, forms pertaining to the UOF package, and departmental time frames.

Finding II: Staff inquiries not completed within time frames.

Five out of nine (56 percent) staff inquiries went beyond the 30-day departmental time frame. The facility is not requesting a 30-day Inquiry Time Extension from the Division of Juvenile Facilities for staff inquiries that exceed 30 working days.

To determine HGSYCF's staff inquiry process, the CPRB conducted several interviews with management and reviewed the Inquiry/Grievance Incident Log for the period of January 1 through December 31, 2007. It was determined there were nine staff inquiries that related to UOF.

After conducting interviews, it was determined that the Superintendent approves the 30-day time extensions, but does not request a 30-day Inquiry Time Extension from the Director of the Division of Juvenile Facilities.

According to DJJ's UOF coordinator, the facilities are required to forward the 30-day Inquiry Time Extension requests to DJJ. However, DJJ does not have staff assigned to receive, track, and/or approve any time extension requests received from the youth facilities.

Criteria:

TDO# 06-73, Section 2107, states in part: "All inquiries shall be completed within 30 working days of the superintendent's review of the complaint/report of misconduct," and "If and when an inquiry is not concluded in 30-days, the superintendent/site administrator shall request a 30-day Inquiry Time Extension through the chain of command to the Director of the Division of Juvenile Facilities."

Recommendations:

Immediately clear any outstanding staff inquiries.

Provide staff to track the facilities 30-Day Inquiry Time Extension requests.

Amend current policy or put temporary controls in place until policy can be amended.

Review of Security Operations

HEMAN G. STARK YOUTH CORRECTIONAL FACILITY

GLOSSARY

CPRB	Compliance/Peer Review Branch
DJJ	Division of Juvenile Justice
DFRC	Departmental Force Review Committee
IFRC	Institutional Force Review Committee
HGSYCF	Heman G. Stark Youth Correctional Facility
TDO	Temporary Departmental Order
UOF	Use of Force